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STATE MANDATED HEALTH COVERAGE

Actuaries' Club of Hartford & Springfield
and Actuaries' Club of Boston
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GENERAL CONTENT

- Report on the development of an issue brief by the AAA workgroup on State Mandated Coverage.
- What is mandated coverage, and how is state reform different than federal?
- What are states looking to accomplish?
- What do they need to consider?

TOPICS

- How the uninsured problem underlies state mandated coverage programs
- Why some states are taking action
- Limits to state authority and purview—federal considerations
- The issue brief from the AAA
- Appendix—source materials on what some states are currently doing or considering.

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THE UNINSURED PROBLEM

- # of uninsured was 47 million in Jan '08, dipped to ~45.7 at mid-yr—(Medicaid & SCHIP enrollment increased during economic downturn)—discontent close to tipping point
- States have lost patience waiting for a federal solution—want a practical fix now—# of uninsured has increased while fed gov't remains deadlocked; some states pursuing solutions specific to their own needs.

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THE UNINSRD PROBLEM (cont)

- Varies by state—uninsured rate varies from 8.8% (MN) to 24.8% (TX). (US Census Bureau, '06/'07. Varies by source & definition.)
- MA plan (Connector) hailed as positive and encouragement to other states, but ... MA had lower uninsured rate than most states and means to fund program & subsidize those who cannot afford to pay full premium (with help from federal gov't & Medicaid). **Would have lost \$400 mil in Medicaid waiver funds w/out reform**
- Future federal funding for MA is in question... **Fed funding over last 3 yrs increased was \$8.5 bil; next 3 yrs is \$10.6--\$2.1 bil in waiver funds allows MA to subsidize coverage for those who don't qualify for Medicaid under trad. rules.**

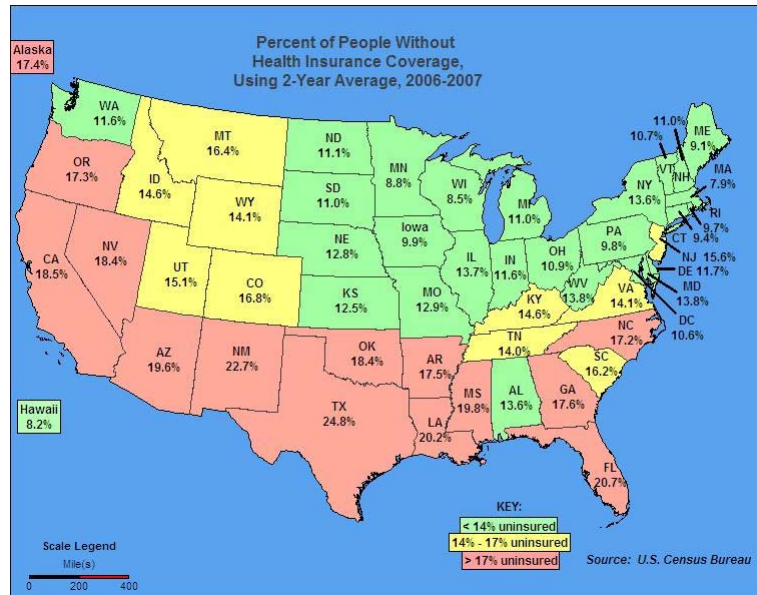
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Variability of Uninsured Rate

(based on US Census Bureau data, '06/'07 avg.)

<u>Unins Rate</u>	<u># of States</u>
l.t. 11%	12
11% to 14%	14
14% to 17%	10
g.t. 17%	14

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BUT...

- States need and rely on federal funding to launch new spending programs
- States budgets are even more susceptible than federal to economic downturn—budget constraints challenge states to continue existing programs, let alone expand them or implement new ones—for example, some state's budgets may be balanced, in part, by cutting Medicaid providers' reimbursement.

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Medicaid

- Medicaid serves as a safety net, but since Medicaid accounts for almost $\frac{3}{4}$ of state health care spending, less money is left over to expand state health care programs during times of relative economic hardship
- Enrollment in gov't health programs increased by ~2.7 million in 2006
- Not all who are eligible are enrolled.

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AND

- Although states desire to reduce the ranks of uninsured and move toward universal coverage, ERISA (under federal authority) limits states' authority to run ER pay or play programs. This is a significant open issue. [10/1: Circuit Court of Appeals upheld Healthy San Francisco—ERs w/ 20+ EEs must cover or pay up to \\$180 PEPM.](#)
- States are not prevented from imposing a tax or fee on all ERs, but the authority of states to tie the tax specifically to an ER health plan is limited.

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What's Likely? What's Not?

- States have the will to change, but not the same authority and economic means of the federal gov't. In the near term, states are not expected to comprehensively solve the uninsured problem across the nation through radical reform.
- States will continue efforts to make affordable health ins more available, esp. if fed does not
- Some states choose a coverage mandate, but the pay penalty is still in question for ER mandate. Penalty under individual mandate is not an issue.

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Employer vs Individual Mandate

- ER based involves play or pay penalty if certain ERs (10+, 20+ EEs) do not provide minimum cvg or contribute a minimum amount to EEs to buy indiv cvg.
- Individual Mandate requires individual, couple, or family to have health ins coverage. (Similar to required auto ins). If not covered, penalty must be paid; MA does so via personal state income tax.
- MA uses both mandates; VT is ER only.

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STATES ALREADY REGULATE...

- insurance, HMOs, managed care, medical providers, facilities, ..., restaurants, ..., etc-- can they take on another large program aimed at achieving universal coverage?
- State/federal relationship is continually changing (as is boundary between actions of each); for example, each state sets Medicaid rules for eligibility, benefit plan, and provider reimbursement.

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AAA WORKGROUP

- Issue brief is titled “[Mandated Health Coverage Purchase: Considerations for Designing a State Program.](#)” Will be available on AAA website
- An overview of actuarial considerations for states proposing such programs—some would also be applicable to a federal program
- Aimed at policymakers & other interested parties
- Intent on remaining objective and non-partisan
- Focused on the actuarial perspective that only our profession can bring to this public dialogue.

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WHAT STATES WANT

- States address health care access, coverage adequacy, and affordability
- Goal of mandated coverage is to reduce # of uninsured and improve access, delivery, and quality
 - Trade-off is cost to state and its taxpayers (some cost is also borne by federal gov't.)
 - Funding is necessary for those that cannot afford coverage.

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Some Potential Goals *(not an exhaustive list)*

- Reduce # of uninsured
- Increase access
- Lower uncompensated care
- Improve preventive care and utilization trends for serious illness (an ounce of prevention ...)
- Indirectly control cost
- Improve quality (esp. for the uninsured)
- Increase provider choice for the uninsured
- Encourage healthy people to be part of the pool.

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A FEW KEY CONSIDERATIONS

- The Health Benefit **Plan**—what benefit set constitutes the minimum level of coverage?
- **Funding**—need a budget extending to long term that is sensitivity-tested for multiple potential variations in enrollment, utilization, cost, funding from taxes/assessments, etc.
- **Modeling** and Available Data—projecting the financial effect of policymaker decisions. How much will it cost—PMPM and total \$?

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A Post-Implementation Consideration

- How to **monitor and manage** the state mandated health coverage program to assure sustainability and deal w/ challenges that will continually & inevitably arise—plan and forecast issues, managing viability and assuring sustainability.

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BENEFIT DESIGN

- Establish a **minimum** threshold for the **benefit plan** to assure adequacy
- **Covered services**—essential vs. non. (Basic services, like inpatient, have lower elasticity than ancillary, e.g., acupuncture, vision, chiro, ...)
- **Covered diagnoses**
- **Member cost-sharing**
- **Cost containment** features: med. mgmt, coord. care, wellness & behavioral initiatives. ...
- Will more than one benefit plan be offered?

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Benefit Design Also Covers Some Broader Concerns Related to Delivery System Structure

- Network & provider choice—will all providers be forced to participate? Affect of network and plan design on demand & utilization. If unit cost in network is lower, can plan use higher member cost-sharing out of network? Provider supply vs utilization demand
- Eligibility and participation rules
- Consider interplay of all of above--benefit, network, eligibility, etc on utilization and cost.

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The FUNDING section—

- Plan & budget
- Identify funding sources,
- Cash flow
- Monitor and manage the above
- Funds must be continually available for on time payments throughout the system

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Funding Sources

- EE and ER contributions
- OOP member cost-sharing
- General revenue, designated or not
- Provider assessments
- Sin taxes
- Other state & federal funding such as DSH
- Play or pay penalties
- Assessments on premium and prem equiv.
- Other sources, recurring and one-time.

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FUNDING (3)

- Program should operate on same financial basis as other insurance programs
- If providers don't get paid in a timely manner or have to perform unreasonable administrative effort to collect payment, they will lose interest

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MODELING & AVAILABLE DATA

- Valuation of cost of alternate proposals
- Determining expected PMPM medical cost of newly covered—consider:
 - pent-up demand vs. learning to use new benefit
 - adverse selection
 - relative health status
- Consider affect of program on physician supply and affect on utilization.

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MODELING (2)

- Administrative costs of implementing and running the program
- Also consider:
 - take-up—the # who will actually enroll
 - crowd out—the # who will drop some form of current private coverage to pick up public subsidized coverage of greater value, and
 - other factors such as demographics, trend, rural vs. urban, condition of economy, private ins. market, state's rating/UW regulations, etc.

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Adverse Selection

- Arises when members choose a health plan based on knowledge of their own h.c. needs
- What if some carriers select preferred risk?
---Need a **risk adjustment/equalization** mechanism to level the playing field.
- Selection can play out in subtle ways—e.g., provider reimbursement might disincent docs to treat less healthy patients if not risk adjstd; if program reimbursement is too low, providers may choose not to take patients.

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Some Policymaker Decisions

- Benefit plan requirements.
- Eligibility req.
Marketing & enrollment process. (How is information about the program made available to the public? Application?)
- What competitive pressures between private HMOs and insurers will be allowed under a managed competition component?
- Potential unintended consequences???

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Issue Brief Summary

- Each state solution will seek to balance social, political, and local market issues
- Compromise between gov't & private sector is required on ongoing basis
- Benefit design is key determinant to cost
- Extensive modeling of forecast and budget is necessary; variability must be addressed using range of inputs to test viability.

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TWO CLOSING BULLETS ON STATE MANDATED COVERAGE

- This is a large and complex undertaking for any state; it involves an enormous effort to launch, a significant effort to sustain, and should not be taken lightly. Like any public program, funding will be an ongoing issue
- We are a long way from universal coverage for the non-elderly; both states & federal gov't will continue to seek solutions—how will a federal mandate interact w/ state's?

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Some Other State Responses

- AFFORDABLE COVERAGE—tie plan cost to income or wage metric. Future program in state of NH, “HealthFirst”—premium for mandated SG health plan must cost less than 10% of median state wage in prior yr.
NOTE: This is **not** an ER or Indiv mandate.
- WA state Basic Health Program—limit cost. Low-cost cvg w/ sliding scale subsidies has enrollment cap of ~105k people in 2008.

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Interaction of Federal & State Reform

- NOT at cross-purposes—one does not negate the other
- Federal gov't generally establishes a “floor”—states can choose to exceed it; examples: MHP, Medicaid eligibility.
- Expanded SCHIP will make more uninsured children eligible for health coverage under Obama plan—a mandate

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Federal Reform under Obama

- Many questions remain re Obama's plan—
 - “National Exchange” would offer private health insurance similar to FEHBP
 - New publicly operated insurance program called “National Plan”—for small firms and all those w/out ESI as alternative to private coverage above
 - Guaranteed issue and elimination of health status as premium basis.

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Federal Reform under Obama (2)

- Provides new tax credit for SG ERs offering ins
- Federally subsidized reinsurance program for catastrophic claims.
- Premium subsidies expected for low income—amount is unspecified as of yet
- Medicaid expansion for very low income

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MA CONNECTOR—Update

- Patrick Holland, CFO, CHICA, spoke at '08 SOA Spring Health Mtg—cf hand-outs on SOA website
- Recent funding info & enrollment stats:
 - 439k are newly insured (~2/3 of formerly uninsured). 367k are non-Medicaid, half of whom are subsidized to some extent:
 - MassHealth (Medicaid expansion) = 72,000
 - Commonwealth Care = 176,000
 - Employer sponsored insurance = 159,000
 - Non-group private insurance = 32,000

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APPENDIX

- Stay informed—there are many websites with information about state programs—the NCSL, KFF, and AHIP have lists of programs, by state.
- <http://www.census.gov/prod/2008pubs/p60-235.pdf>
- <http://www.ncsl.org/programs/health/universalhealth2007.htm>
- <http://www.ncsl.org/programs/health/healthmc.htm>
- <http://www.kff.org/uninsured/upload/State%20Health%20Reform1.pdf>
- AHIP: “Selected Significant 2008 State Access Proposals: Major Provisions Checklist (as of September 2, 2008)”

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Thank You!



Sturbridge Village

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